

EP13.62 Non-gynecological causes of pelvic pain: Mesothelial cysts and Tarlov cysts, case reports

German C. Torres^{1, 2}, Camilo C. Rueda^{1, 2}, Clara Alvarado^{1, 2}, Andres Camacho¹, Diana A. Alfonso^{1, 2}, Laura Cortes¹, Viviana Amaya^{1, 2} // 1. Clinica El Country, 2. Clinica La Colina. Bogotá, Colombia.

We describe two patients with chronic pelvic pain and non-gynecological pelvic masses.

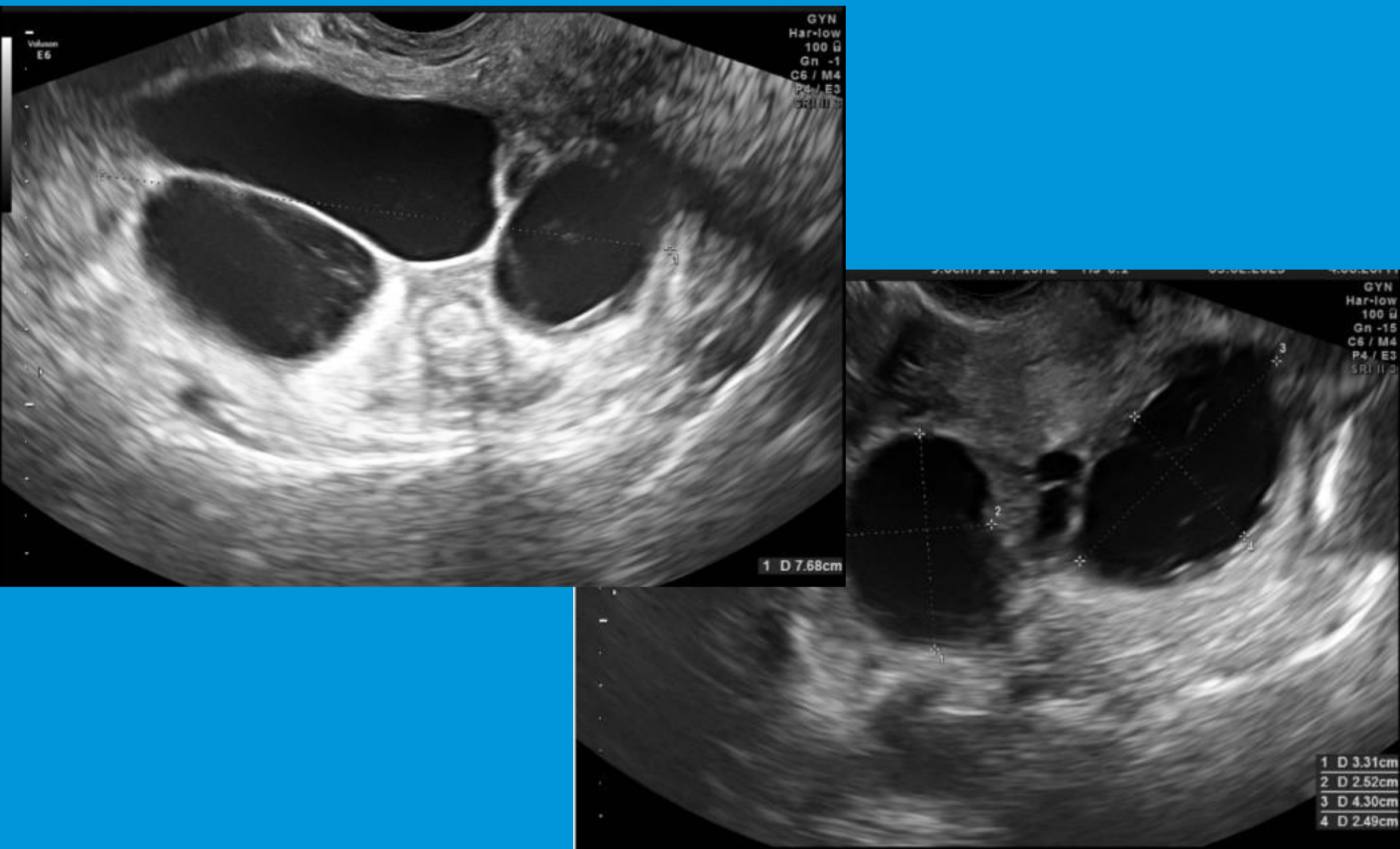
Case 1: A 32-year-old (G1) with chronic pelvic pain and no surgical history presented with an acute exacerbation of pain. Prior imaging (ultrasound and MRI) suggested bilateral hydrosalpinx. Physical examination revealed diffuse pelvic tenderness and pain in the Pouch of Douglas. Transvaginal ultrasound(TVUS) showed multiple thin-walled, anechoic cystic structures in the retro-uterine and right adnexal regions, separated from the ovary. Similar painful cystic images were noted in the left adnexa. Suspecting adnexal torsion, emergency laparoscopy was performed, revealing multiple anechoic pelvic cysts consistent with peritoneal inclusion cysts. The cysts were drained, and wall biopsies were taken. Pathology confirmed mesothelial cysts with reactive hyperplasia and inflammation. The patient remained asymptomatic one month postoperatively.

Case 2: A 47-year-old (G1) with chronic pelvic pain was followed for a "complex right ovarian cyst" identified a year prior. Previous tumor markers were negative, and a pelvic MRI had identified sacral perineural cysts. Follow-up TVUS revealed normal ovaries; however, two large, avascular, heterogeneous cystic lesions (41.6 x22.3 mm and 50.1 x 30.9 mm) were observed near the pelvic wall, posterior to the ovaries. These findings correlated with the sacral perineural cysts previously seen on MRI. Retrospective review confirmed these were the same lesions misidentified as ovarian cysts previously. The patient is currently under expectant management with neurosurgical follow-up.

Conclusion

Chronic pelvic pain has diverse etiologies. Clinicians must consider non-gynecological origins when adnexal masses are atypical or separate from the ovaries. TVUS is a primary diagnostic tool, but correlation with specialized imaging like MRI is essential to avoid unnecessary surgical interventions for benign non-gynecological findings.

CASE 1



Figures 1. and 2 Anechoic cystic structures in the retro-uterine and right adnexal regions, separated from the ovary

CASE 2



Figure 3. Avascular, heterogeneous cystic lesions near the pelvic wall, posterior to the ovaries.